Meeting Notes

March 26, 2015
10:00am to Noon
Dial In: 866.620.7326, Conference Code: 8286985516
Leavenworth DCF - Pioneer Room, 515 Limit, Suite 100, Leavenworth, KS 66048

Those in attendance:
Ralph Simon, Angie Ranking, Russell Nittler, Kerrie Bacon, Liz Long, Stephanie Sanford, Hal Schultz, Edward Nicholas, Marilyn Kubler, Barb Conant, Sean Gatewood, James Bart, Joe Ewert, Elizabeth Ryan

Those attending by telephone:
Michelle Heydon, Mary Ralph, Dorothy Noblit, Aldona Carney, Kristi Berning, Jane Adams

Review of Minutes from Last Meeting:

Russell Nittler, KDHE

Concerns about referencing Case Managers rather than Care Coordinators continuity:

- Define Care Coordinators from Targeted Case Managers
- Care Coordinators are with MCOs
- Targeted Case Managers are independent people.

Note: The December 2014 minutes/notes were correct per recording.

MCOs do refer to their Care Coordinators differently:

- Amerigroup: Service Coordinators
- United: Care Coordinators
- Sunflower: Care Coordinators

All 3 MCOs should be using the same Care Coordinator language.

News from KanCare/Eligibility

Russell Nittler, KDHE

Our new computer system KEES is scheduled to go live on June 29th. The week before June 29th we will have no computer access to make changes or approve new people for KanCare. This is because they have to shut down or old system and transfer all of the data into the new system, and bring the new system up. When the new system goes up after June 29th because we will be adjusting and learning the new system this will slow us down in eligibility. The State has not planned on communicating this to members because members should not see a difference. This will be communicated to providers because during this week the State has an emergency approval system where they will be handing out paper medical cards so providers needed to know so they understand what is going on if they see these.

The Governor ordered a reorganization of ERO. Eligibility of the elderly and disabled is currently determined at your local DCF office. If this ERO goes through the DCF office will be transferring all of the eligibility work to KDHE. That will take place in January of 2016. The only items that will stay at the local DCF offices would be foster care, medical, and adoption subsidy. KDHE is currently making some draft plans but we don't have anything official to share but it will probably be set up differently. The question was asked does KDHE have local offices? Russell stated, no. So there is one central location in Topeka? It may be rolled out as a Clearinghouse model in which one place in Topeka will do all eligibility for adult medical. That is the way it is done for children, pregnant women, and low-incomes families currently. Aldona asked, I thought eligibility for the I/DD community went through the CDDOs. Is that going to change? Russell stated that part does not change. What your CDDO does is the functional eligibility for the I/DD waiver which will stay the same. What I am discussing is the *financial* eligibility. 3161; are we going to continue this process? Russell stated that process will probably stay the same. The 3160 and 3161 is a form that gets passed around to all of the people involved in determining the eligibility for a nursing home or HCBS services. The question was asked; what will I have to do if KDHE is taking care of eligibility instead of the local DCF office? Russell stated, you will fill out your paper application and mail it to our central office. A consumer can get an application at an access point our call us and we will mail one. We do have a TTY line but we don't have a Video Phone Line. Still planning access points. We have 12 out stationed workers and hope to add another 18. That way if you do need some help with the application you have someone to contact. With the new computer system the State is going to push for people to apply online.

The question was asked, will there be stakeholders in the planning process as you move forward? Russell stated, I don't see that in the current plans. The KanCare Ombudsman office is looking into training their volunteers to be able to pick up that slack. This would be a good opportunity to include providers and stakeholders in planning a process that they have a stake in. If you include them that could help make a more streamlined process.
From KDADS perspective this is viewed as a positive step. With KDHE being the State Medicaid agency and consolidating the eligibility process within KDHE that involves one less agency. This should streamline the process. With KEES coming into effect eligibility will become more passive. Currently the managed care organizations are notifying their members when the eligibility yearly reviews are coming up so they are receiving the information from DCF through KDADS to offer assistance to members in completing eligibility reviews. Russell stated, KEES is going to change the way that KDHE/DCF does reviews. Currently, when your care comes up for review every year you have to fill out a whole new application. With KEES a lot of those reviews are going to be prepopulated forms and some of them will be passive so if you get a form and all of the information is correct you won't have to do anything and will get approved for another year. Some people will have to sign-off that it is current and turn it back in. Other people will just get a letter stating that we have reviewed your case and you are approved for another year which are called super passive. These may include people who are in nursing homes that their only income is Social Security. Our system is going to check their Social Security amount and we know they are still in a nursing home because we are getting billed. This will also work for the I/DD population. I can't tell you it is going to be by population because it is going to be determined by how close that person is to the resource limit; it will be different case by case. The MCO's do not reach out to the pregnant women, low income individuals, and families to help fill out eligibility forms. There has been a challenge for consumers to turn in that once a year form. A lot can change within that year including a change in their address and since the member only received a medical cards once instead of monthly like it used to be we don't know the member has moved unless they contact us. The new computer system is going to speak with the post office that we have a valid address. The question was asked, will the process of changing the member address change with the new system? Russell stated, not really. KDHE will have staff and a contractor will help us with this. We are going to have a call center that when a member calls the address will be changed. In the past our pregnant women, low income, and children that have had passive reviews that are in a Clearinghouse model currently.

KanCare Ombudsperson Report – Fair Hearings

Kerrie Bacon, KDADS and Dorothy Noblit, KDHE

This is a combined report of 4th quarter and an annual report. The 4th quarter report is at the beginning and the annual report is attached at the end. The first part is the accessibility piece that shows the number of calls is average for the year. The number of calls of the year 2014 is higher than 2013. But, we did not have e-mails included in 2013 so it is difficult to say that we have a good comparison there. Page 2 has information about the volunteer program. We have a start date of the volunteer program of August 1. We will begin the training with the startup in the Kansas City metro area and Wichita. Also, this includes the topics of the training which we hired Pam Brown. The question was asked, who have you recruited to be volunteers? Kerrie stated, we have an application process that is going to start in May. Anyone that wants to apply in those areas will be able too. Russell stated, that KDHE is providing Medicaid training for our sister agencies and we will be opening this to the public in the fall. There will be one on eligibility, state plans, working healthy, social security, and others. Page 3 shows the top issues were for 4th quarter which include Medicaid services, home and community based general issues, appeals and grievances, and billing. Page 4 shows the contact information and the response rate on how quickly things were responded too. By the end of the quarter 82% had been responded to but were not closed. The average number of days for an item to be closed is 7 days. The question was asked, what is the resource category? Kerrie stated, these are the resources used to help people with their issues. For example, if I e-mail, call, mail, or forward someone to KDHE for assistance I consider that a KDHE resource. Used issues issue resolved is checked when I am able to answer the question without using another resource. Russell stated, on page 3 our number one issue is Medicaid eligibility; the resources used the most is KDHE. When you have a problem with eligibility do you reach out to DCF or KDHE? Kerrie stated, I call KDHE because I do not have contacts for DCF. If KDHE does not have the answer I need, they have a contact person that I need to speak with at a high level with DCF. Russell asked, do you receive as many calls for pregnant women, low income, and families as you do for the elderly/disabled population? Kerrie stated, I believe it is

about a 35% and 65% split. With 35% being pregnant women, low income, and families with some being critical cases needing immediate attention. The annual report starts on page 5. We continue to update our web page so that it has more and better information on it. The lunch and learn is constantly changing because we continue to make it broader in its topics. The data is just comparing quarters. If you look at issues page there appeals and grievances and billing are two topics that have held out. The question was asked, what is unspecified. Kerrie stated, sometimes someone will call in but won't say what they are needing help with. They just call and leave a message asking to be called back. If we call back twice and do not receive a return phone call we consider the issue done. Some people will call several different places and by the time we reach them someone has helped them with their issue. The question was asked, who do you refer the guardianship issues too? Kerrie stated, it just depends on what those issues are and what types of questions they have. I see other is trending up significantly, what is causing this? Kerrie stated, there is a lot of other things coming through that don't fit into these categories. You can't have more than 20 categories because it is unmanageable. The one's we picking I felt were important. I thought after a year to relook at the categories and maybe change them but then you won't have anything to compare. The question was asked, Medicaid Eligibility from qtr. 3 to qtr. 4 more than double the issues, what is the driver for that? Russell stated, the first thing is a lack of return phone calls from the party involved in the medical eligibility. The other probably medical eligibility would be the process of how a person goes from regular Medicaid eligibility to HCBS services or nursing home.A grievance is your first level like filing a complaint such as someone was rude to me. A lot of the things included in the grievance category are not appealable. Grievances are accepted at the KanCare Clearinghouse and the MCO's. Appeals are accepted by the MCO's and are when you are appealing a decision. The State Fair Hearing level is above the appeal level and involves that State Office of Appeals that is separate from KDHE and KDADS. Members can do both at the same time or can go straight to a State Fair Hearing without going through the appeal process first. Dorothy Noblit stated, Fair Hearings are divided among eligibility fair hearings and all other types of hearings. I handle all other types of hearings. There is a legal group at KDADS that handles the waiver hearings and the eligibility hearings. These are medical types of hearings that involved denials of some type of service or a provider's bill that has not been paid for a variety of reasons. There was a question at the last meeting pertaining to appeals. Liz Long stated, the reporting that the MCO's provide us include waiver participants. For grievances in quarter 3 all three MCO's are tracking similarly for TBI for quarter 3 and 4 from 3 to 7. For TA was between 1 and 8 in quarter 3 and went down in 4th quarter. For SED it went up a little bit. The PD average seems to have the highest number of grievances but averaged about the same by quarter. For I/DD in quarter 3 they ranged from 2 to 10 by MCO but down a little in 4th quarter range of 3 to 8. FE was between 9 and 19 for quarter 3 and quarter for was between 7 and 20. For WORK there was 1 for each quarter. For Autism there was 1 only in quarter 4.When reviewing appeals the numbers were much lower. The high for TBI in quarter 3 was 10 and quarter 4 it was 11. For TA the high in quarter 3 was 8 and quarter 4 it was 5. For SED in quarter 3 the high was 12 and quarter 4 it was 4. For PD in quarter 3 the high was 12 and quarter 4 it was 14. I/DD in quarter 3 the high was 13 and quarter 4 it was 21. For FE there were no appeals in quarter 3 and quarter 4 there were 2. WORK had no appeals during quarter 3 and 4. Russell stated, when I speak with Dorothy more things get overturned at the appeal level than they do at the State Fair Hearing level. Your chance of having an action changed is greater with your MCO appeal process versus the State Fair Hearing process. I would say the reason for that is if an MCO sees that it is going to go to a State Fair Hearing and they are not secure the MCO may reverse whatever situation brought the appeal on. Liz stated, we do ask for an explanation for an appeal determination so we do have a general reason even though we are not categorizing them. Russell stated, in eligibility we have a lot of Fair Hearing withdrawals because either the person ends up getting the benefit they were applying for or once they sit down with someone they understand why they were denied. The question was asked, who is responsible for letting members know about the different levels of grievances? Russell stated; that would be an educational item that you can get from the MCO and it is included in your enrollment packet.

KanCare Executive Summary – Charts and Graphs

Liz Long, KDHE

On page 1 the first charge is the number of people there are and the second chart is how much money each of those people are. These include all medical programs not just KanCare exclusively. Pertaining to capitation payments; we pay out much more for long-term care.

Page 2 pertains to denied claims. I am comparing last year's quarter 3 to this year's quarter 3 to see how things are changing year to year. It has leveling out having gone back and looked pre-KanCare the numbers are very similar. The bottom half is by service type. We have been tracking the number if duplicate denials which is about 15% of these numbers. This means that a provider has billed more than once for the same claim. Aldona stated, I'm on a quality assurance board for the Community Living Opportunities and was informed that Sunflower is denying prompt care for the clients. It is cheaper for prompt care than it is to go to the ER. Is there a reason why Sunflower is denying this service? Michelle from Sunflower stated, I am not able to answer that but I will get back with you. Liz stated value-added services are additional services that were not part of the State plan are staying stable. In-lieu of services are steadily growing.

Case Manager Continuity:

MCO's

Russell stated, we are going to hear from each MCO how they inform members that they are getting a new care coordinator. United stated, we contact the member immediately by phone letting them know they have a new care coordinator. Part of the reason we do that so quickly is that we have 7 days to go out and see that member. We have received some communication that members would like additional contact through a letter which we are developing and it is in the final internal approval process so members have something in writing. James Bart asked; 'Does your website have your case coordinators contact information?' United stated, I don't believe it does. At any time a member can contact member services and receive information. The number for member services is on the back of the member's card. Michelle from Sunflower stated whenever we have a new member we have to make contact within 7 days with the member. When we have changes in care coordinators the new case manager makes contact with the member to introduce themselves and give the member updated contact information by phone. Vanessa for Amerigroup stated the process depends on the reason that change is occurring. For a planned transition the transfer is immediate. The expectation is that the outgoing service coordinator will contact the members letting them know about the change and give them contact information for their new service coordinator. For a non-planned transition the service coordinator is responsible for contacting the manager who would reassign members to new service coordinators as needed.

Marilyn has challenges with Amerigroup in communication with the consumer. One of the ongoing issues; we are not able to call directly to the Care Coordinator (AMG=Service Coordinator), we have to either send an email Jody Jeffers or someone over there and we'd get a call back or we call the general office number and they have to find the Care Coordinator who will eventually call us back. If we could get a direct line to the Care Coordinator, that would help our situation. The thinking about the policy of calls going through the central point is to have the person routed to the correct Care Coordinator and/or whoever may be covering for them on that particular day.

How much of the turnover that might be over the next couple years. Russell will put the request for turnover numbers (by quarter) on the agenda for the June meeting.

Advisory Committee moved. Russell will check to see if it is a one-time occurrence.

Future Meeting: June 30th in Ottawa at the ADRC.

dl/caa/RN